health connect
Joint Health Management Board
of Fresno Unified School District

2025

Benefits Information Guide

Guidelines/Evidence of Coverage

The benefit summaries listed on the following pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the Plan Booklet and/or Evidence of Coverage. The Evidence of Coverage or Plan Booklet is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

The HMO member must receive the services and supplies at a health plan facility or skilled nursing facility inside the service area except where specifically noted to the contrary in the Evidence of Coverage.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the Plan Booklet or Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Plan Booklet, the Evidence of Coverage or Plan Booklet will prevail.

The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

Discover Your Benefits

Welcome to your 2025 Benefits Information Guide! Since 2006, Fresno Unified School District's Joint Health Management Board has worked tirelessly to manage and maintain the highest quality health and wellness benefits on behalf of the District's employees. Comprised of members from several District groups, including management and union representatives, the Board promotes informed and proactive health and wellness decisions to ensure that our plan participants are responsible healthcare consumers.

This Benefits Information Guide is your initial resource to understanding and selecting the best benefit options for you and your family. We encourage you to review this booklet in its entirety to learn more about eligibility, how to enroll or make changes when applicable, each benefit available to you as an eligible employee, summaries of covered benefits and how to contact each insurance carrier if you need assistance.

We appreciate the hard work and dedication you bring to Fresno Unified School District. For more information about the employee benefits and wellness programs described herein, please refer to your plan documents and insurance booklets available at www.jhmbhealthconnect.com/benefits. If you have any questions, please contact the Benefits Department at 559.457.3520.

Eligibility & Enrollment

Eligibility & Enrollment

Time to answer some questions…

Who can enroll?

Permanent employees working a minimum of 4 hours a day or 20 hours a week are eligible and are required to participate in the benefits program. Eligible employees may also choose to enroll family members, including a legal spouse/state registered domestic partner and/or children.

Children are considered eligible if they are your or your legal spouse's/domestic partner's:

- Biological child, stepchild or adopted child up to the age of 26
- Child up to the age of 26 subject to a Qualified Medical Child Support Order (QMCSO)
- Child under permanent legal guardianship up until it ceases due to child's legal age attainment, death, marriage, military enlistment, adoption or any other reason declared by a court
- Child of any age if they are incapable of self-support due to a physical or mental disability that existed prior to such child reaching the age of 26 (proof of disability required)

When does coverage begin?

Benefits for eligible **new hires** commence on the first day of the month following your date of hire. Eligible employees must complete their benefit enrollment forms and submit to the Benefits Department within 31 days of benefit eligibility.

New full-time employees who do not actively make benefit elections during their initial eligibility period will be automatically enrolled with "Employee Only" coverage in Medical Plan A, Delta Dental PPO Incentive Plan, VSP Vision and Standard Basic Life Insurance plans. Employees must complete enrollment forms to add coverage for dependents, or select alternate plans.

New part-time employees that work less than 20 hours a week may enroll in the UnitedHealthcare Dental HMO and/or VSP Vision Plan at their own expense.

Your enrollment choices remain in effect through the end of the benefits plan year, December 31, 2025.

TIP

If you miss the enrollment deadline, and are automatically enrolled in benefits as described above, you will not be able to change your benefits coverage until the next Open Enrollment period unless you experience a special enrollment event during the plan year. Please review the HIPAA Special Enrollment Rights Notice on page 36 for more information.

How do I get started with my enrollment?

Online Enrollment – Check Your District Email for Link & Login Instructions

By your start date, you should receive an email at your District email address from the Benefits Department. After reviewing your benefits options, complete your enrollment online. The District's online enrollment system will walk you through each of your enrollment decisions, including:

- Electing your benefits coverage
- Selecting your eligible dependents to cover
- Reviewing information about how to enroll in your Flexible Spending Accounts (FSAs) with American Fidelity

You can start and finish your enrollment process when it's convenient for you using the unique hyperlink sent to your District email address.

If you do not receive an email or have questions when completing your online enrollment, contact the Benefits Department at 559.457.3520.

What if my needs change during the year?

If you are declining enrollment for your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll your dependents in this Plan if your dependents lose eligibility for that other coverage (because of separation/divorce, termination of employment or reduction in hours, death or cessation of employer contribution), or if your dependents were receiving COBRA coverage and their eligibility for COBRA has expired. However, you must request enrollment within 31 days after your dependents' other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll your new dependents. You must request enrollment within 31 days of the life event. The District also allows you to enroll a child placed in your permanent legal guardianship outside of open enrollment, subject to the Special Enrollment requirements. If you are enrolling a new dependent as a result of birth, adoption, placement for adoption, or permanent legal guardianship, you can also enroll your Spouse or State Registered Domestic Partner if he or she was not previously enrolled in the Plan, but only if he or she is otherwise eligible to participate in the Plan.

Part-time employees are only eligible to enroll in dental and/or vision insurance if they experience a special enrollment event.

Special enrollment rights may also exist in the following circumstances:

- If your dependents experience a loss of eligibility of Medicaid or a State Children's Health Insurance Program ("SCHIP") coverage and you request enrollment within 60 days after that coverage ends; or
- If your dependents become eligible for a state premium assistance subsidy through Medicaid or a SCHIP program with respect to coverage under this Plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

To request Special Enrollment or to obtain more information, contact the District's Benefits Department at 559.457.3520.

Paying for Coverage

Fresno Unified School District and the Joint Health Management Board strives to provide you with a valuable benefits package at a reasonable cost. Based on your benefit selections and coverage level, you may be required to pay for a portion of the cost. The Cost of Coverage section in this guide outlines the rate and frequency of the payroll deduction for each benefit.

No Opting Out

All eligible active District employees shall be required to participate in the Health Care Plan and pay the monthly contributions and assessments, at least at the Employee Only level, for the Plan(s) or coverage. You will automatically be enrolled in Medical Plan Option A, Delta Dental PPO Incentive Plan, VSP Vision and Standard Basic Life Insurance if you don't make an election within 31 days of benefit eligibility. Coverage for your dependent(s) and/or choosing an alternate plan is available at your expense.

It is important to note that if coverage is waived for your dependents, the next opportunity to enroll in our group benefit plans would be the next open enrollment period or when a special enrollment event occurs.

Medical

Medical

Which plan type is right for you?

Fresno Unified School District and the Joint Health Management Board offer two PPO plan options, Medical Plan A and Medical Plan B, administered by Delta Health Systems and utilizing the Aetna provider network, and one Deductible HMO plan, administered by Kaiser Permanente.

To help guide your plan selection, the following pages include details concerning how the plans operate, as well as plan highlights. Please note, if there is a discrepancy between the information in this Benefits Information Guide, and the Plan Booklet/Evidence of Coverage (EOC) document, the Plan Booklet and EOC will prevail. For your reference, an illustration of employee contibutions is listed in the Cost of Coverage section of this guide.

Using a PPO Plan

With a Preferred Provider Organization (PPO) plan, you have greater flexibility and choice to use both in-network and out-of-network providers. However, you are encouraged to receive services from the Aetna network doctors, specialists and facilities. By doing so, you obtain a higher level of benefit than if services were rendered from an out-of-network provider. Also, claim forms are submitted to the plan on your behalf when services are received from within the network. Additional information regarding use of a PPO plan includes:

- You and any enrolled dependent(s) are permitted to visit any doctor or facility without a referral from a Primary Care Physician (PCP)
- Certain services, such as doctor's visits, may require fixed-dollar payment up front, referred to as a copayment
- Before the plan will pay certain medical expenses, you may be required to pay a plan specific amount, referred to as a deductible
- Once the deductible has been fulfilled, the plan will pay a large percentage of the cost of your care, known as coinsurance. You are then financially responsible for the remaining cost up to the out-of-pocket maximum

You can find an Aetna provider by going online to www.aetnaresource.com/p/FresnoUSD. Scroll down and click on the **Find an Aetna Choice POS II Provider** purple button. Within the **Continue as a guest** section, enter your location and click **Search**. You can then type the name or type of provider you are looking for within the **What do you want to search for** section. Press Enter, and a list will be provided based on your search parameters. You can then filter and sort results specific to your needs, such as language, gender preference, and provider type.

NOTE: It is important to use Aetna's dedicated microsite for the District's plan when searching for medical providers. The use of any other site, including Aetna.com, will provide inaccurate results based on our plan structure. In addition, please keep in mind the following services and providers are not part of your Aetna network through the District's PPO plans, even though you may see them listed in the online directory:

- Acupuncture
- Chiropractic
- Dental
- Mental health
- Pharmacy
- Substance abuse
- Sutter Health Systems providers
- Vision

Visit www.jhmbhealthconnect.com/help-center/locate-a-provider/ for details on finding providers for these specific services.

Using a Deductible HMO Plan

As a member of the Kaiser Permanente Health Maintenance Organization (HMO), you will receive your medical care from an integrated network of physicians and specialists at a medical office, medical center, or affiliated hospital near you. Additional information regarding use of the Kaiser Permanente HMO Deductible plan includes:

- You may choose a primary care physician for you or your family members at choose.kaiserpermanente.org/fusd or receive assistance in selecting a doctor or scheduling your first appointment by calling 800.278.3296
- Initial referrals for most specialty care services will be coordinated by a Kaiser Permanente physician. However, many departments such as OB/GYN, Optometry, Psychiatry and Additional Medicine are self-referred
- There is a deductible with the Kaiser Permanente HMO plan; however, there are no claim forms to submit unless you receive emergency services outside of a plan facility
- Preventive care services are covered at 100%

A summary of covered services under the Kaiser Permanente HMO Deductible plan is listed on the following pages. For a complete listing of covered services for each plan, please refer to your Evidence of Coverage (EOC) or Plan Booklet.

Medical (Continued)

Kaiser Permanente – On the Go!

The KP mobile app gives you a suite of tools to use on the go! Use this application with your Kaiser Permanente user ID and password to:

- See your health history at your fingertips
- Refill prescriptions for yourself or another member
- Check the status of your prescription order
- Schedule, view, and cancel appointments
- Access your message center to email your doctor or another KP department
- Find KP locations and facilities near you

Search for Kaiser's mobile app in the App Store or Google Play to get started!

Free Preventive Health Care

The Federal Health Care Reform law requires insurance companies to cover in-network preventive care services in full, saving you money and helping you maintain your health. Such preventive services include:

- Preventive care doctor's visits
- Annual checkups
- Well-baby and child visits
- Several types of immunizations and screenings

To confirm your preventive care services are covered, refer to your Plan Booklet or associated Evidence of Coverage.

Informing You of Health Care Reform

California residents are required to have minimum essential health coverage. You can obtain health insurance through our benefits program or purchase coverage elsewhere, such as a State or Federal Health Insurance Exchange.

For information regarding Health Care Reform, please visit www.healthcare.gov. For information regarding the Individual Mandate in the state of California, please refer to the State of California Franchise Tax Board or visit their website at www.ftb.ca.gov. You can also visit www.coveredca.com to review information specific to the Covered California State Health Insurance Exchange.

Prescription Drug Coverage

Many FDA-approved prescription medications are covered through the benefits program. Important information regarding your prescription drug coverage is outlined below:

PPO Medical Plans A and B:

- Prescription drugs are administered through Elixir/MedImpact using the "Select EX Formulary"
- The Elixir/MedImpact plan includes a four-tier prescription benefit. Tiered prescription drug plans require varying levels of payment depending on the drug's tier and your copayment or coinsurance will be higher with a higher tier number.
    - **Tier 1** includes many generic drugs for high blood pressure, high cholesterol, depression, diabetes and thyroid conditions.
    - **Tier 2** includes all other generic drugs. Generic drugs are required by the FDA to contain the same active ingredients as their brand-name counterparts.
    - **Tier 3** includes preferred brand name drugs.
    - **Tier 4** includes non-preferred brand name drugs.
- If you purchase a brand name drug when there is a generic equivalent available, you will pay the brand copay plus the difference in cost between the brand name and the generic. Exceptions are available if the brand name medication is authorized as medically necessary by Elixir/MedImpact.
- Up to a 90-day supply available at retail or through mail order.
- Maintenance medication refills are required to be dispensed in a 90-day supply by a pharmacy in the Rx90 network (Birdi Mail Order, Rite Aid, Walgreens or Costco retail pharmacy). If you are currently taking a maintenance medication, you will need to have your prescription transferred to an Rx90 network pharmacy. For a list of maintenance medications, please visit www.ElixirSolutions.com and click Providers, then navigate to Prescriber Resources and Covered Drug Lists. The list of maintenance medications can be found by clicking on the Rx90 Drug List.
- Specialty medications must be filled by Birdi Specialty Pharmacy, with the exception of limited distribution drugs. For questions or to learn more, please visit www.ElixirSolutions.com or call **877.437.9012**.
- Certain specialty medications are subject to a variable copayment. Birdi Specialty Pharmacy representatives will help you enroll in drug manufacturer assistance to reduce your out-of-pocket costs below the standard copayment tiers described above. If you are ineligible for the drug manufacturer assistance program, the standard copayment tiers apply.

Deductible HMO Plan C:

- The Kaiser prescription plan includes a two-tier prescription benefit.
    - **Tier 1** includes generic drugs. Generic drugs are required by the FDA to contain the same active ingredients as their brand-name counterparts.
    - **Tier 2** includes preferred brand name drugs. Non-preferred brand name and specialty drugs are covered under Tier 2 if approved through an exception process.
- Up to a 30-day supply available at retail, and up to a 100-day supply through mail order.
- For a Kaiser formulary prescription drug list(s) or more information on the mail order service, go to www.kp.org/formulary.

Why pay more for prescriptions?

Use Mail Order

Save time and money by utilizing a mail order service for maintenance medications. A 90 or 100-day supply of your medication will be shipped to you, instead of a typical 30-day supply from a walk-in pharmacy.

Shop Around

Some pharmacies, such as those at warehouse clubs or discount stores, may offer less expensive prescriptions than others. Call ahead to determine which pharmacy provides the most competitive price.

Over-the-Counter Options

For common ailments, over-the-counter drugs may provide a less expensive alternative that serves the same purpose as prescription medications.

Plan Highlights	Aetna Plan A		Aetna Plan B	
	In-network	Out-of-network[1][2]	In-network	Out-of-network[1][2]
Annual Calendar Year Deductible*	Medical Only	Medical/Mental Health	Medical Only	Medical/Mental Health
Individual	$250	$750	$1,000	$3,000
Family	$500	$1,500	$2,000	$6,000
Maximum Calendar Year Out-of-pocket	Medical/Mental Health	Medical/Mental Health	Medical/Mental Health	Medical/Mental Health
Individual	$2,100	$10,000	$5,700	$12,000
Family	$4,200	$20,000	$11,400	$24,000
Lifetime Maximum	Unlimited		Unlimited	
Professional Services				
Primary Care Physician (PCP)	$15 Copay	40%	$25 Copay + 20%	50%
Specialist	$15 Copay	40%	$25 Copay + 20%	50%
Preventive Care Exam	No Charge[3]	Not Available	No Charge[3]	Not Available
Well-baby Care (first 5 years)	No Charge[3]	Not Available	No Charge[3]	Not Available
Diagnostic X-ray and Lab	No Charge	40%	20%	50%
Complex Diagnostics (MRI/CT Scan)	No Charge	40%	20%	50%
Therapy[4], including Physical, Occupational and Speech	No Charge	40%	20%	50%
Hospital Services				
Inpatient[4]	No Charge	40%	20%	50%
Outpatient Surgery[4]	No Charge	Not Available	20%	Not Available
Emergency Room	$100 Copay (copay waived if admitted)		$100 Copay + 20% (copay waived if admitted)	$100 Copay + 20% (copay waived if admitted)
Urgent Care	$35 Copay	$35 Copay + 40%	$35 Copay + 20%	$35 Copay + 50%
Maternity Care	Dependent children are only covered for preventive care services			
Physician Services (prenatal or postnatal)	$15 Copay	40%	$25 Copay	50%
Hospital Services	No Charge	40%	20%	50%
Mental Health & Substance Abuse services administered through SimpleBehavioral				
Mental Health & Substance Abuse	Pre-Authorization required by SimpleBehavioral for all inpatient mental health and substance abuse services. See page 14 for more details.			
Chiropractic & Acupuncture services administered through SimpleMSK				
Chiropractic & Acupuncture	See page 14 for more details.			
Prescription Drug Coverage administered through Elixir/MedImpact				
Prescription Drug Maximum Calendar Year Out-of-pocket	$400/individual $800/family	N/A	$900/individual $1,800/family	N/A
Retail and Mail Order Prescription Drugs (30-day supply)				
Tier 1 Generic Drugs	$0 Copay	Not Covered	$0 Copay	Not Covered
Tier 2 Generic Drugs	$10 Copay		$10 Copay	
Tier 3 Preferred Brand Name	$35 Copay		$35 Copay	
Tier 4 Non-Preferred Brand Name	$50 Copay		$50 Copay	
Retail and Mail Order Prescription Drugs (90-day supply)				
Tier 1 Generic Drugs	$0 Copay	Not Covered	$0 Copay	Not Covered
Tier 2 Generic Drugs	$20 Copay		$20 Copay	
Tier 3 Preferred Brand Name	$70 Copay		$70 Copay	
Tier 4 Non-Preferred Brand Name	$100 Copay		$100 Copay	

* The annual deductible is waived for all covered family members of a dual-covered member enrolled in the PPO Plan A or PPO Plan B.
(1) Member pays coinsurance applicable to Usual, Customary and Reasonable (UCR) rate
(2) Refer to the Your Rights and Protections Against Surprise Medical Bills notice on page 57.
(3) Plan deductible waived
(4) Requires pre-authorization

The above information is a summary only. Please refer to your Evidence of Coverage or Plan Booklet for complete details of Plan benefits, limitations and exclusions

Plan Highlights — Kaiser Deductible HMO Plan C

	In-Network Only
Annual Calendar Year Deductible	
Individual	$250
Family	$500
Maximum Calendar Year Out-of-pocket	
Individual	$2,500
Family	$5,000
Lifetime Maximum	
Individual	Unlimited
Professional Services	
Primary Care Physician (PCP)	$15 Copay(1)
Specialist	$15 Copay(1)
Routine Physical Maintenance Exam	No Charge(1)
Well-Child Preventive Exam (through age 23 months)	No Charge(1)
Most X-rays and Laboratory Tests	$10 Copay per encounter
Complex Diagnostics (MRI, most CT scans and PET scans)	$50 Copay per procedure
Most Physical, Occupational and Speech Therapy	$15 Copay
Hospital Services	
Inpatient	No charge
Outpatient Surgery	$100 Copay per procedure
Emergency Room	$100 Copay
Urgent Care	$15 Copay(1)
Maternity Care	
Physician Services (prenatal or postnatal)	No Charge(1)
Hospital Services	No Charge
Mental Health & Substance Abuse	
Inpatient	No Charge
Outpatient	Individual visit: $15 Copay(1) Group visit: $7 Copay (Mental Health)(1) / $5 Copay (Substance Abuse)(1)
Vision Care	
Routine Eye Exams with a Plan Optometrist	No Charge(1)
Eyeglasses or contact lenses every 24 months	Allowance up to $175(1)
Retail Prescription Drugs (Up to a 30-day supply)	
Most Generic Drugs	$10 Copay
Most Brand Name Drugs	$35 Copay
Most Specialty Drugs	$35 Copay
Mail Order Prescription Drugs (Up to a 100-day supply)	
Generic Drugs	$20 Copay
Most Brand Name Drugs	$70 Copay

(1) Deductible Waived

The above information is a summary only. Please refer to your Evidence of Coverage or Plan Booklet for complete details of Plan benefits, limitations and exclusions.

Supplemental Services

Supplemental Services

Mental Health & Substance Abuse

If you are enrolled in Medical Plan Option A or B, your mental health & substance abuse coverage is through SimpleBehavioral. Pre-authorization is required for inpatient mental health and substance abuse services. If you are enrolled in Medical Plan Option C, your coverage is through Kaiser.

SimpleBehavioral Plan Highlights	Medical Plan Options A or B	
Mental Health Services	In-Network(1)	Out-of-Network(2)(3)
Inpatient	Plans A & B: Covered at 100% as certified medically necessary. Inpatient, partial and day treatment Unlimited visits/calendar year/member	Plan A: 60% UCR after deductible Plan B: 50% UCR after deductible
Outpatient	Plans A & B: $10 Copay per visit Unlimited visits/calendar year/member	Plan A: 60% UCR after deductible Plan B: 50% UCR after deductible
Substance Abuse Services	In-Network(1)	Out-of-Network(2)(3)
All levels of substance abuse	Plans A & B: Covered at 100%	Plan A: 60% UCR after deductible Plan B: 50% UCR after deductible

Pre-authorization applies to inpatient services only.

(1) There is no deductible for In-Network mental health and substance abuse services.
(2) Out-of-Network Medical & Mental Health Deductibles are combined. Please refer to page 11 for Out-of-Network Annual Calendar Year Deductibles.
(2) Member pays coinsurance applicable to Usual, Customary and Reasonable (UCR) rate.

Any questions pertaining to your mental health and/or substance abuse coverage can be directed to SimpleBehavioral by calling 888.425.4800, emailing info@simpletherapy.com or visiting their website at simpletherapy.com/go/fresnousd.

Chiropractic & Acupuncture

When you're seeking relief from pain caused by an accident, injury, or muscle strain, or just looking for a natural healthcare approach, our Chiropractic and/or Acupuncture Benefits may be able to assist you. These benefits offered by SimpleMSK provide you access to licensed professionals at a discounted rate.

Chiropractic Plan Highlights	Medical Plan Options A, B & C
Chiropractic Services by SimpleMSK Provider (deductible waived)	$5 Copay then 100% of the SimpleMSK contract rate
Chiropractic Services by Non-SimpleMSK Provider (after deductible) Outside 100 miles of Fresno ONLY Referral must be given by a Physician & Pre-Certified by SimpleMSK	Plan A & C: 60% UCR after $100 deductible(1) Plan B: 50% UCR after $100 deductible(1)
Chiropractic Diagnostic X-Ray Benefit (after deductible)	100% UCR Limited to $100 per Benefit Calendar Year
Visits	Up to 28 visits per Calendar Year **Note:** For treatment exceeding 12 visits per calendar year, chiropractor must submit a "twelve visit review" and SimpleMSK must pre-certify additional visits for the remainder of the calendar year.

(1) Deductible does not apply for dual covered members.

Acupuncture Plan Highlights	Medical Plan Options A & B	
	SimpleMSK Provider	Non-SimpleMSK Provider
Acupuncture Visit (20 visits per Calendar Year)	$20 Copay Deductible waived	Up to $20 reimbursement Deductible waived

The above are brief benefit summaries only. Please refer to the Plan Booklet (Plans A and B) and the Kaiser Permanente Evidence of Coverage for additional information.

Note: Acupuncture benefits for Plan Option C are covered through Kaiser facilities at a $15 Copay (deductible waived). Check out SimpleMSK's website at simpletherapy.com/go/fresnousd or contact them at 877.519.8839 to discuss how to use the program and find a participating provider near you.

Supplemental Services (Continued)

Virtual Physical Therapy

If you're enrolled in Medical Plan Option A or B, you and your covered dependents aged 13 and older can take advantage of the SimpleTherapy Virtual Physical Therapy Program. This program offers an easy, at-home solution for common issues like back pain, arthritis, and tendonitis. You'll get instant access to over 2,000 guided video exercises, as well as live virtual visits with a physical therapist. Other benefits include a personalized care plan, unlimited coaching support, and a care pack to help you get started—putting you on the path to greater comfort and improved well-being.

To create your free account, visit simpletherapy.com/go/fresnousd.

Need to see a doctor on demand?

Telehealth is convenient for diagnosing and treating many non-acute medical conditions using your phone, tablet or computer.

Teladoc (Medical Plan Options A & B)

Teladoc provides telehealth services for PPO Plan Options A & B. With Teladoc, you can connect with leading board-certified physicians in your state through the internet or telephone, helping you avoid emergency rooms and urgent care centers. Teladoc can assist with prescription medications and with many non-emergency illnesses including:

- Allergies
- Arthritic pain
- Asthma
- Bronchitis
- Colds and flu
- Diarrhea
- Insect bites
- Pharyngitis
- Conjunctivitis (pink eye)
- Rash
- Respiratory infection
- Sinusitis
- Skin inflammation
- Sore throat
- Sprains & strains
- Urinary tract infection
- Sports injuries
- Vomiting

Telehealth services are provided at no cost, and no deductible applies when using Teladoc.

To get started, you can:

- Download the Teladoc App (from the Apple App Store or Google Play Store)
- Go online to www.Teladoc.com
- Call 800.TELADOC (835.2362)

For more information regarding this service, please visit www.jhmbhealthconnect.com/using-your-telehealth-benefits-with-teladoc.

Kaiser Permanente (Medical Plan Option C)

As a Plan Option C participant, Kaiser Permanente provides you with a myriad of ways to meet with your physician or schedule an appointment. If you are pressed for time and/or prefer to meet with your physician via video, you can schedule an appointment in minutes by phone or using your mobile phone or computer.

Kaiser recommends that participants download the KP Preventive Care app for the most convenient experience in scheduling appointment and conducting video visits. However, you can also visit their website at www.kp.org/mydoctor/videovisits for more details on how to use their telehealth services.

Wellness Program

Wellness Program

A healthier you starts here – mind and body!

Healthy, active lifestyles can help reduce the risk of chronic disease and may lower your annual healthcare costs. We care about your total well-being and encourage all employees to engage in our wellness resources.

The JHMB's WellPATH Employee Wellness Program is designed for, and by, Fresno Unified School District employees. WellPATH offers a variety of wellness-related educational opportunities and activities throughout the year to help employees along their path to better healing, including:

- Wellness Challenges
- Fitness Classes
- Personal Training
- Wellness Coaching
- Online Wellness Assessments
- On-site Biometric Screenings
- Flu Vaccinations
- Educational Seminars
- Wellness Newsletters

WellPATH
Your Path to Better Health

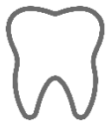
Employees and their eligible dependents who voluntarily participate and successfully complete certain wellness related activities become eligible to win great prizes. These include gift cards for receiving your flu vaccination at a WellPATH event and annual wellness screenings, as well as prizes for participating in wellness challenges. Visit www.JHMBHealthConnect.com/wellpath for more details about the wellness offerings available to you and your family.

Please note: Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact WellPATH at **833.WELLPATH (935.5728)** or email WellPATH@JHMBHealthConnect.com and we will work with you (and, if you wish, your doctor) to find a wellness program with the same reward that is right for you in light of your health status. Some prizes may be taxable to the recipient (e.g., gift cards). Contact WellPATH with any questions.

Dental

Dental Plan

A smile is the nicest thing you can wear.



Your Dental Plan Options

You and your eligible dependents have the opportunity to enroll in a Dental Health Maintenance Organization (HMO) plan offered by UnitedHealthcare or a PPO Incentive Plan offered by Delta Dental. We encourage you to review the coverage details and select the option that best suits your needs.

Using the Plan

The Delta Dental PPO Incentive plan is designed to incentivize dental health maintenance while giving you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind, you'll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists.

To find an in-network Delta Dental PPO Incentive Plan dentist, go to www.deltadentalins.com and search the Provider Network, or call 866.499.3001.

UnitedHealthcare Dental HMO (Dental Direct) is unique for a DHMO dental plan. You are not required to select a provider as long as you and your dependents go in-network. If you receive services from a provider outside of the approved network, you would be responsible for paying the entire dental bill yourself.

To find a UnitedHealthcare Dental HMO dentist, go to www.myuhc.com and select **Find a Dentist**, or call 800.999.3367.

Note:

- Part-time employees are eligible to enroll in the UnitedHealthcare Dental HMO plan only.
- **Dual Coverage Not Allowed for the Same Dental Plan**
  If both you and your spouse are an employee of Fresno Unified School District and qualify for coverage as a Primary Enrollee, neither of you may enroll as a Dependent of the other for the same dental plan. In addition, only one of you may enroll your dependent child(ren) for the same dental plan. However, if you and your spouse enroll in separate dental plans (i.e., one enrolls in Delta Dental and the other enrolls in UHC), you may cover your spouse and dependent child(ren) in each plan.

Plan Highlights	Delta Dental PPO Incentive Plan		UnitedHealthcare Dental HMO
	In-network(1)	Out-of-network(1)	In-network Only
Annual Calendar Year Deductible			
Per Person	N/A	N/A	N/A
Family Maximum	N/A	N/A	N/A
Calendar Year Maximum	$2,500	$1,500	N/A
Preventive Services			
Office Visit	Benefits increase 10% each year enrollee receives dental care: 70% first year, 80% second year, 90% third year, 100% fourth year	Benefits increase 10% each year enrollee receives dental care: 70% of UCR first year, 80% of UCR second year, 90% of UCR third year, 100% of UCR fourth year	No Charge
X-rays			No Charge
Cleanings			No Charge
Sealants (per tooth)			No Charge
Restorative Services			
Amalgam Fillings			No Charge
Composite Fillings			No Charge
Periodontics (gum treatment)			
Scaling & Root Planning	Benefits will decrease by 10% if enrollee does not receive dental care each year	Benefits will decrease by 10% if enrollee does not receive dental care each year	No Charge
Gingivectomy (4+ teeth)			No Charge
Endodontics (root canal therapy)			
Pulpotomy			No Charge
Root Canal			No Charge

(1) Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.
The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Dental Plan (Continued)

Plan Highlights	Delta Dental PPO Incentive Plan		UnitedHealthcare Dental HMO
	In-network	Out-of-network	In-network Only
Oral Surgery			
General Anesthesia	Benefits increase 10% each year enrollee receives dental care: 70% first year, 80% second year, 90% third year, 100% fourth year	Benefits increase 10% each year enrollee receives dental care: 70% of UCR first year, 80% of UCR second year, 90% of UCR third year, 100% of UCR fourth year	No Charge
Simple Extraction			No Charge
Soft Tissue Impaction			No Charge
Complete or Partial Bony Impaction			No Charge
Crowns & Inlays	Benefits will decrease by 10% if enrollee does not receive dental care each year	Benefits will decrease by 10% if enrollee does not receive dental care each year	
Inlay / Onlay (2 surfaces)			No Charge
Crowns			No Charge
Prosthetics & Bridges			
Bridges	50%	50% of UCR	No Charge
Denture Adjustment	50%	50% of UCR	No Charge
Complete or Partial Denture	50%	50% of UCR	No Charge
Other Services			
Implant	50% up to $1,000		$1,950 Copay
Orthodontia Services			
Child / Adult Orthodontia Phase 1 & 2	50% to $2,000 per Lifetime for Adults and Children		$1,250 maximum out-of-pocket expense for 24-month treatment plan

(1) Resin, porcelain and any resin to metal or porcelain to metal crowns and pontics are excluded on molar teeth. If titanium, noble or high noble metals are requested for filings, crowns, pontics, bridges or prosthetic devices, there will be an additional charge, based on the amount of the metal used. Flexible base partial dentures are subject to an additional charge based on additional laboratory cost.

UCR = Usual, Customary and Reasonable

The above information is a summary only. Please refer to your Evidence of Coverage or Plan Booklet for complete details of Plan benefits, limitations and exclusions.

Vision

Vision Plan

Keep a clear focus on your sight.

Vision coverage for members enrolled in Medical Plan A or B is offered by VSP Vision as a Preferred Provider Organization (PPO) plan. If you are enrolled in Medical Plan C, your vision coverage is offered by Kaiser Permanente.

Using the Plan

As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount.

Any questions pertaining to your vision coverage can be directed to VSP Vision by calling **800.877.7195**, or by visiting their website at www.vsp.com. To locate an in-network VSP Vision provider, go to www.vsp.com, and click on **Find a Doctor**. You can search by location, office or doctor. Available to all VSP members at no extra cost, your benefits go even further when you visit a *Premier Edge provider/location* – this includes private practice doctors and retail locations nationwide. You can be eligible to receive exclusive rebates, advanced exam technology, and more when seeing a Premier Edge provider.

Practices that display the VSP PREMIER edge indicator on the **Find a Doctor** page of www.vsp.com participate in VSP Premier Edge.

Plan Highlights	VSP Choice Vision PPO	
	In-Network	Out-of-Network
Exam – Every Calendar Year	$5 Copay for Exam & Glasses $0 Copay at Premier Edge Providers Up to $60 Copay for Contact Lens Exam	Up to $73 Reimbursement
Lenses – Every Calendar Year		
Single	Covered in Full	Up to $31 Reimbursement
Bifocal	Covered in Full	Up to $50 Reimbursement
Trifocal	Covered in Full	Up to $65 Reimbursement
Frames – Every Other Calendar Year	$175 Retail Allowance $175 Walmart/Sam's Club/Costco Allowance $225 Visionworks/Featured Frame Brands Allowance 20% savings on the amount over your allowance	Up to $70 Reimbursement
Contacts – Every Calendar Year		
Medically Necessary	Covered in Full	Up to $324 Reimbursement
Cosmetic	$130 Allowance	Up to $115 Reimbursement

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Flexible Spending Accounts

Flexible Spending Accounts (FSA)

Make your money work for you.

The District, in partnership with American Fidelity, offers flexible spending account plans that let you use pre-tax dollars to cover eligible healthcare and dependent care expenses. There are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

FSA Type	Detail
Healthcare FSA	• Can reimburse for eligible healthcare expenses not covered by your medical, dental, and vision insurance. • Maximum contribution for **2025** is **$3,200.***
Dependent Care FSA	• Can be used to pay for a child's (up to the age of 13) childcare expenses and/or care for a disabled family member in the household, who is unable to care for themselves. • Eligibility rules require that if you are married, your spouse needs to be working, looking for work or attending school full-time. • Maximum contribution for **2025** is **$5,000 per household.***

*Annual contribution amount may be less than $3,200 or $5,000 as the amount is pro-rated based on hire date. You have 31 days from eligibility date to enroll.

Please note: Consult your tax advisor for additional taxation information or advice.

Enrolling and Using an FSA

Your annual contribution amount, within the maximum limit, must be determined at the time of enrollment each year. FSA plans do not automatically renew each year. If you currently participate in the District's FSA plan, you must re-enroll and set your annual contribution amount for the upcoming year. Once enrolled, you will have online access to view your FSA balance, check on a reimbursement status, and more. Visit www.americanfidelity.com to access American Fidelity's online portal. For more information on how the Healthcare FSA works, please watch the following video: Healthcare FSA | Video | American Fidelity; For more information regarding how a Section 125 Plan works, please watch the following video: Section 125 | Video | American Fidelity.

Examples of eligible expenses, as determined by the Internal Revenue Service (IRS), and additional information are below. Visit www.americanfidelity.com/claims/fsa-hsa-eligibility-list to view a more comprehensive list of eligible expenses.

Account Type	Examples of Eligible Expenses
Healthcare FSA	• Deductibles, copays and coinsurance, as well as out-of-pocket costs for medical, dental and vision services, including chiropractic and acupuncture services • Prescription drugs and over-the-counter medications with a prescription are considered eligible • Explicit guidelines for determining eligible expenses have yet to be provided by the Internal Revenue Service (IRS); for a list of potential eligible expenses that may be covered by a Flexible Spending Account (FSA), review Internal Revenue Code (IRC) section 213(d). IRS Publication 502 (Medical and Dental Expenses) may be used as a guide for what expenses may be considered by the IRS to be for medical care; however, the guidelines should be used with caution when trying to determine what expenses are reimbursable under an FSA(1)
Dependent Care FSA	• Eligible child care, nanny services or residential disabled adult daycare for your dependents • Dependents claimed on your federal income tax return, including those under age 13 and those of any age who are unable to care for themselves, who live with you for more than half of the taxable year and do not provide more than half of his/her own support, would be considered eligible dependents for this FSA • To determine potential eligible employment-related expenses, view IRC sections 129 and 21. IRS Publication 502 (Child and Dependent Care Expenses) may also be used as a guide for what expenses may be considered employment-related; however, Publication 502 should be used with caution when trying to determine what expenses are reimbursement under a Dependent Care FSA(1)

(1) **Please note:** This is informational only and not intended to serve as legal, tax or financial advice. Participants in a Healthcare FSA or a Dependent Care FSA should consult their tax advisor before making any changed to their plan.

Flexible Spending Accounts (FSA) (Continued)

Receiving Reimbursements

Keep itemized receipts in a safe place. The IRS or American Fidelity may request a copy to substantiate a claim. If you are required to submit a receipt or some form of claim documentation, and fail to comply, reimbursement may be denied.

Although the FSA plan year runs from January 1, 2025 through December 31, 2025, the plan allows a grace period through March 15, 2026, allowing FSA plan participants to incur eligible expenses up to 2 ½ months after the plan year ends. The FSA plan also allows a run-off period through March 31, 2026, allowing FSA plan participants to submit a reimbursement request for eligible expenses incurred during the plan year and grace period (from January 1, 2025 through March 15, 2026).

You can submit a manual reimbursement request by:

- **Fax:** 844.319.3668
- **Mail:** American Fidelity Assurance Company, Attn: Flex Account Administration, P.O. Box 161968, Altamonte Springs, FL 32716
- **Online:** www.americanfidelity.com (you must be registered online to process claim)
- **Mobile Device Using AFmobile:** Create an AFmobile account by downloading the app from the Apple App Store or the Google Play Store. To learn more about the AFmobile app, we invite you to visit www.americanfidelity.com/support/mobile-app.

You may receive your manual reimbursement either by a mailed check or by direct deposit into your personal Checking or Savings Account.

For more details about using an FSA, be sure to contact American Fidelity's local Fresno Office at 866.504.0010. You can also get help calling the Customer Service line at 800.662.1113.

Healthcare FSA Plan Debit Card

Upon enrollment in the Healthcare FSA Plan, you will have the option to request a Healthcare FSA Plan Debit Card through American Fidelity. You can use this debit card to pay your provider for eligible healthcare expenses rather than paying out of pocket, or to purchase eligible healthcare FSA plan products within the FSA plan year. Your Healthcare FSA Plan account will be automatically deducted for the eligible expense amount, and you will not have to wait for reimbursement from American Fidelity. Although payment will come directly from your Healthcare FSA Plan account, you must save all receipts, as proof of the eligibility of the expense is required by the Internal Revenue Code (IRC) regulations. For more information on using the Healthcare FSA Plan Debit Card, visit: Benefits Debit Card Support | American Fidelity

The Healthcare FSA Plan and Termination

If you are a participant in your Healthcare FSA plan and you are terminated, your funds may be preserved and you may have other options available to you. Please note that your termination date becomes the last day of your FSA plan year. You may submit reimbursement for eligible expenses through the rest of the plan year; however, you can only do so for eligible claims that are incurred prior to your termination date.

It is important that you contact American Fidelity at 866.504.0010 if you have any further questions regarding your FSA healthcare plan fund at the time of termination. Your failure to act in conjunction with your Healthcare FSA plan may cause your fund to be permanently forfeited after your termination. If you have a balance in your Healthcare FSA plan approaching the end of the plan year or upon termination, you may purchase eligible healthcare FSA plan items through the FSA Store: www.fsastore.com.

Life and AD&D

Life and AD&D

Protection for your loved ones.

Basic Life and AD&D

In the event of your death, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

Your Coverage

Paid for in full by the Joint Health Management Board, the benefits outlined below are provided by The Standard:

Basic Life and AD&D Benefit

Age of Insured	Benefit Amount
Less than 25	$30,000 Regardless of Age
25-29	
30-34	
35-39	
40-44	
45-49	
50-54	
55-59	
60-64	
65-69	
70+	

IRS Regulation: Employees can receive employer paid life insurance up to $50,000 on a tax-free basis and do not have to report the payment as income. However, an amount in excess of $50,000 will trigger taxable income for the “economic value” of the coverage provided to you.

TIP

Required! Are Your Beneficiaries Up to Date?

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- You can change your beneficiary designation at any time (Community property rules may apply. Please refer to plan summary or forms for information.)
- You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated.
- To select or change your beneficiary, contact the Benefits Department at 559.457.3520.

Voluntary Dependent Life Insurance

Voluntary Dependent Life Insurance is available for dependent(s) of employees who qualify for the Employer Paid Basic Life and AD&D. Dependent coverage may be purchased by the employee at a cost of $6.00 per year.

Schedule for Voluntary Dependent Life Insurance

Dependent	Benefit Amount
Spouse Dependent	$1,500
Children to age 26	$1,500

Voluntary Employee Paid Additional Life Insurance

If you are insured under the Basic Life plan and would like to supplement your employer paid insurance, additional Life coverage for you and/or your dependents is available for purchase through The Standard.

- **For employees:** Increments of $10,000 up to a $300,000 maximum (amount may not exceed 5x annual earnings)
- **For your spouse/state registered domestic partner:** Increments of $5,000 up to a $150,000 maximum
- **For your child(ren):** 14 days old up to 6 months of age, $100; 6 months old up to age 26, $5,000 or $10,000
- **Guarantee Issue Amount:** There are no requirements for a medical questionnaire if you apply for the Guarantee Issue Amount within 31 days after you first become eligible. If you apply within 31 days after you first become eligible for coverage: The Guarantee Issue Amount for you is $50,000, $25,000 for your spouse/state registered domestic partner. The insurance for your child(ren) is all guarantee issue.

Any amounts of insurance over the guarantee issue benefit are subject to review of good health by the insurance company. Insurance amounts subject to review will not be effective until the insurance company approves.

If you do not elect Voluntary Additional Life insurance when you are first eligible, you will be required to submit a health questionnaire, also known as Evidence of Insurability (EOI) to The Standard. An EOI will also be required if you wish to become insured for an amount greater than $50,000 or if you wish to insure a spouse for an amount greater than $25,000. The Benefits Office will supply employees with the proper forms if they are interested.

Please consider the following if you are purchasing Voluntary Additional Life for a dependent:

- You must purchase coverage for yourself in order to purchase coverage for your spouse or child(ren)
- Spouse or Child amount cannot exceed 100% of the employee's additional life benefit
- All children will be insured for the same amount
- For child(ren) coverage, one rate is charged regardless of the number of children in the family

Cost of Voluntary Life Coverage

Age of Insured	Tenthly Rate per $1,000
Less than 30	$0.072
30–34	$0.084
35–39	$0.108
40–44	$0.204
45–49	$0.312
50–54	$0.468
55–59	$0.732
60–64	$0.972
65+	$1.608

Dependent Child Coverage

Benefit Amount	Tenthly Premium
$5,000	$1.80
$10,000	$3.60

Please note: Benefits coverage may reduce when you reach age 65. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Please refer to your Plan Booklet for exclusions and further detail.

Employee Assistance Program (EAP)

Employee Assistance Program (EAP)

Your free and confidential go-to resource.

Fresno Unified School District and the Joint Health Management Board understand that you and your family members might experience a variety of personal or work-related challenges. Through the Claremont EAP, you have access to resources, information, and counseling that are fully confidential and no cost to you.

Program Component	Coverage Details
Who can utilize	All employees/retirees, dependents of employees/retirees, and members of your household
Consultations Available for Subjects Such As:	• Childcare and eldercare assistance • Emotional issues like stress, anxiety and depression • Marital, relationship or family problems • Bereavement or grief counseling • Substance abuse • Identity theft • Financial services to support issues including budgeting, debt management, financial planning and more • Legal services provides one consultation per issue (25% discount) to guide you through a divorce, child custody, real estate issues and other topics • Work/Life services to offer referrals for important matters such as Adoption Assistance or School/College Assistance, among other subjects
Number of sessions	5 face-to-face sessions per year per family member per incident

How to Access:

- By phone: **800.834.3773**
- Online: **www.claremonteap.com**

Costs & Required Notices

Cost Breakdown

All of your rates in one place.

health connect
Joint Health Management Board
of Fresno Unified School District

The rates below are effective January 1, 2025 – December 31, 2025

Coverage Level	Payroll Deduction	
	Employee Monthly	Employee Tenthly
Medical Plan Option A (Aetna PPO)		
Employee Only	$160	$192
Employee and Spouse/State Registered Domestic Partner	$220	$264
Employee and Child(ren)	$175	$210
Employee and Family	$230	$276
Medical Plan Option B (Aetna PPO)		
Employee Only	$60	$72
Employee and Spouse/State Registered Domestic Partner	$90	$108
Employee and Child(ren)	$70	$84
Employee and Family	$100	$120
Medical Plan Option C (Kaiser Permanente Deductible HMO)		
Employee Only	$160	$192
Employee and Spouse/State Registered Domestic Partner	$220	$264
Employee and Child(ren)	$175	$210
Employee and Family	$230	$276
UnitedHealthcare Dental HMO		
Employee and Family	No Cost	No Cost
Delta Dental PPO Incentive Plan		
Employee Only	No Cost	No Cost
Employee + One Dependent	$33.05	$39.66
Employee + Two or more Dependent	$51.57	$61.88
VSP Vision		
Employee and Family	No Cost	No Cost

Available to Part-Time Employees Only	Payroll Deduction	
	Employee Monthly	Employee Tenthly
UnitedHealthcare Dental HMO		
Employee and Family	$43.75	$52.49
VSP Vision		
Employee and Family	$12.15	$14.58
Employee and Family CSEA Only (Employees with 3 years of service)	$7.59	$9.11

Dual-covered coordination of benefits only applies when both employees elect and pay for cross coverage(s).

Fresno Unified School District's Health and Welfare Benefits Annual Notice Packet

For the 2025 Plan Year

Dear Valued Employee,

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law.

Enclosures:

- Medicare Part D Creditable Coverage Notice
- Women's Health and Cancer Rights Act (WHCRA) Notice
- Newborns' Mothers Health Protection Act (NMHPA) Notice
- Health Insurance Portability & Accountability Act Non-Discrimination Requirements
- HIPAA Special Enrollment Rights Notice
- "Change in Status" Permitted Midyear FSA Election Changes
- Mental Health Parity and the Public Health Service Act
- HIPAA Notice of Privacy Practices
- Children's Health Insurance Program (CHIP) Notice
- General Notice of COBRA Continuation Rights
- Uniformed Services Employment & Reemployment Rights Acts Notice of 1994, Notice of Right to Continued Coverage Under USERRA
- Employee Rights & Responsibilities under the Family Medical Leave Act
- EEOC Wellness Program Notice
- Surprise Billing Notice – "Your Rights and Protections Against Surprise Medical Bills"

Should you have any questions regarding the content of the notices, please contact us at:

Fresno Unified School District

Attn: Benefit Department

2309 Tulare Street, Fresno, CA 93721

559.457.3520

Medicare Part D
Creditable Coverage Notice

Important Notice from Fresno Unified School District
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Fresno Unified School District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Fresno Unified School District has determined that the prescription drug coverage offered by the Fresno Unified School District Health Care Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan while enrolled in Fresno Unified School District coverage as an active employee, please note that your Fresno Unified School District coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare

prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Fresno Unified School District coverage as a former employee.

You may also choose to drop your Fresno Unified School District coverage. If you do decide to join a Medicare drug plan and drop your current Fresno Unified School District coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Fresno Unified School District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact Fresno Unified School District Benefits Office listed on page 38 for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Fresno Unified School District changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator at **559.457.3520**.

Each of the medical plan options available through Fresno Unified School District Health Plan currently covers mastectomies and reconstructive surgery. Coverage is subject to each plan's deductibles, coinsurance and benefit provisions. These provisions are generally described in the Plan Booklet or Explanation of Coverage.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Health Insurance Portability & Accountability Act Non-discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in Fresno Unified School District's group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days (60 days if the lost coverage was Medicaid or Healthy Families) after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll your new dependents. The District also allows you to enroll a child placed in your permanent legal guardianship outside of open enrollment, subject to the Special Enrollment requirements. If you are enrolling a new dependent as a result of birth, adoption, placement for adoption, or permanent legal guardianship, you can also enroll your Spouse or State Registered Domestic Partner if he or she was not previously enrolled in the Plan, but only if he or she is otherwise eligible to participate in the Plan.

Part-time employees are only eligible to enroll in dental and/or vision insurance if they experience a special enrollment event.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact the Benefits Office.

"Change in Status" Permitted Midyear FSA Election Changes

Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will remain in place until the next Open Enrollment period. Flexible Spending Account election(s) will also remain in place, unless you have an approved "change in status" as defined by the IRS. Please note mid-year changes are only allowed for Dependent Care Accounts (DCA) and not Health FSA's. Health FSA mid-year changes are only for death or termination of employment. DCA's can occur with a life event change (marriage, divorce, etc.).

Examples of permitted "change in status" events include:

- Change in legal marital status (e.g., marriage [2], divorce or legal separation)
- Change in number of dependents (e.g., birth [2], adoption [2] or death)
- Change in eligibility of a child
- Change in your / your spouse's / your registered domestic partner's employment status (e.g., reduction in hours affecting eligibility or change in employment)
- A substantial change in your / your spouse's / your registered domestic partner's benefits coverage
- A relocation that impacts network access
- Enrollment in state-based insurance Exchange
- Medicare Part A or B enrollment
- Qualified Medical Child Support Order or other judicial decree
- A dependent's eligibility ceases resulting in a loss of coverage [3]
- Loss of other coverage [2]

You must notify the Benefits Office within 31 days of the above change in status, with the exception of the following which requires notice within 60 days:

- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)

Mental Health Parity and the Public Health Service Act

Group health plan sponsored by the State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act (the "PHSA"). However, self-funded group health plans sponsored by state and local governments, including school districts are permitted to

elect to be exempt from some of the PHSA requirements. The benefits provided by Aetna, SimpleBehavioral, Elixir/MedImpact, Claremont EAP, SimpleMSK, and Delta Dental constitute the self-insured portions of the Fresno Unified School District Employee Health Care Plan (the "Plan").

If you have questions regarding your mental health or substance abuse coverage, please contact SimpleBehavioral at 888.425.4800.

The JHMB is not opting out of other applicable HIPAA requirements. It is not opting out of the provisions regarding standards relating to benefits for mothers and newborns, coverage for reconstructive surgery following a mastectomy, and coverage of dependent students on medically necessary leaves of absences.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Joint Health Management Board ("JHMB"), sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by Fresno Unified School District, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the by Fresno Unified School District HIPAA Privacy Officer or

Fresno Unified School District Benefit Department
Attn: Steven Shubin
2309 Tulare Street
Fresno, CA 93721
559.457.3520

Effective Date

This Notice as revised is effective October 2024.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates
We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law
We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation
If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;

- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research
We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures
You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period ABC Company has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what

information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA**.**

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html.

To file a complaint with the Plan, telephone or write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremiumassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA - Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**

Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program| Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone:304-558-1700

	CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Fresno Unified School District and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 31 days after the qualifying event occurs. You must provide this notice to: Fresno Unified School District, Attn: Benefits Office, 2309 Tulare Street, Fresno, CA 93721. You may be required to provide supporting documentation (e.g. a divorce/legal separation decree).

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. When you call, you may be asked to provide some or all of the following information: (1) Employee's name; (2) Employee's Social Security Number; (3) the name(s) and social security.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start. These rules are different for people with End Stage Renal Disease (ESRD).

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/agencies/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Fresno Unified School District
Attn: Plan Administrator
2309 Tulare Street, Fresno, CA 93721
559.457.3520

Uniformed Services Employment & Reemployment Rights Acts Notice of 1994, Notice of Right to Continued Coverage Under USERRA

Right to Continue Coverage

Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

- You are absent from work due to service in the uniformed services (defined below);
- You were covered under the Plan at the time your absence from work began; and
- You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage

If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if You do not Elect to Continue Coverage?

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these

requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage

The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

Length of Time Coverage Can Be Continued

If elected, continuation coverage can last 24 months from the date on which employee's leave for uniformed service began. However, coverage will automatically terminate earlier if one of the following events takes place:

- A premium is not paid in full within the required time;
- You fail to return to work or apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Reporting to Work / Applying for Reemployment

Your right to continue coverage under USERRA will end if you do not notify Human Resources of your intent to return to work within the timeframe required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:

Period of Uniformed Service	Report to Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as is possible
31–180 days	Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, then as soon as is possible
181 days or more	Submit an application for reemployment within 90 days after completion of your service
Any period if for purposes of an examination for fitness to perform uniformed service	Report by the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods

Definitions

For you to be entitled to continued coverage under USERRA, your absence from work must be due to "service in the uniformed services."

- "Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency
- "Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS)

Employee Rights & Responsibilities under the Family Medical Leave Act

Basic Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, child or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness [(1)]; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. [(1)]

Benefits & Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months [(2)], and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days’ notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider; or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: (866) 4US-WAGE ((866) 487-9243) TYY: (877) 889-5627 www.wagehour.dol.gov

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.
[2] The FMLA definitions of “serious injury or illness” for current service members and veterans are distinct from the FMLA definition of “serious health condition”
[3] Special hours of service eligibility requirements apply to airline flight crew employees

EEOC Wellness Program Notice

Notice Regarding Wellness Program

WellPATH is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for a variety of health conditions (the blood panel for WellPATH Wellness Screenings currently include: HbA1c test, Complete Blood Count Panel, Comprehensive Lipid Panel, and Thyroid Screening. The thyroid screening is available to members 35 years or older that have not tested within the last 5 years). You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of a $50 gift card for completing the health screening requirements or a $25 gift card for receiving your flu vaccination at a WellPATH sponsored event. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive a $50 gift card. This gift card may be reportable income. Please consult a tax professional for further information.

Additional incentives and prizes may be available for employees who participate in certain health-related activities, such as the successful completion of a WellPATH Wellness Challenge. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting WellPATH at WellPATH@delapro.com.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as enrollment in personal training, behavior modification and/or health coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Fresno Unified School District may use aggregate information it collects to design a program based on identified health risks in the workplace, WellPATH will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are a Pinnacle Training Systems health coach or your Primary Care Physician (only upon your request) in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact WellPATH at **833.WELLPATH (935.5728)** or email WellPATH@delapro.com.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you should not be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:

    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, the following information and resources are available to help you understand your rights:

Assistance by telephone – You may contact the U.S. Department of Health & Human Services at (800) 985-3059 to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to learn more about protections from surprise medical bills and for contact information for the state department of insurance or other similar agency/resource in your state to learn if you have any rights under applicable state law. Please click on your state in the map for contact information to appear.

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Directory & Resources

Below, please find important contact information and resources for Fresno Unified School District.

Information Regarding	Group / Policy #	Contact Information	
Enrollment & Eligibility			
Initial Enrollment: • Benefits & Risk Management Department		559.457.3520	www.fresnounified.org/departments/benefits
Eligibility / PPO: • Delta Health Systems		800.807.0820	www.deltahealthsystems.com
Plan Booklet / Forms / SBCs / Policies: • JHMBHealthConnect			www.jhmbhealthconnect.com
Medical Coverage			
Aetna • Medical Plan Option A • Medical Plan Option B	 891049 891049	 800.807.0820 800.807.0820	 www.deltahealthsystems.com (Eligibility/claims) www.aetnaresource.com/p/FresnoUSD (Find a provider)
Elixir/MedImpact Prescription Benefit	Rx Bin#009893	833.640.2849	www.ElixirSolutions.com
SimpleBehavioral (Mental Health & Substance Abuse)		888.425.4800	simpletherapy.com/go/fresnousd
Medical Coverage			
Kaiser Permanente • Medical Plan Option C	 603815	 800.464.4000	 choose.kaiserpermanente.org/fusd
Chiropractic / Acupuncture Coverage			
SimpleMSK		877.519.8839	simpletherapy.com/go/fresnousd
Dental Coverage			
Delta Dental • Dental PPO Incentive Plan	 00697	 866.499.3001	 www.deltadentalins.com
UnitedHealthcare Dental • Dental HMO	 711904	 800.999.3367	 www.myuhc.com
Vision Coverage			
VSP Vision • Vision	 40156117	 800.877.7195	 www.VSP.com
Life, AD&D and Disability			
The Standard • Basic Life/AD&D • Voluntary Additional Life • Travel Assistance Service	 600762 C 600762 B	 559.457.3520 559.457.3520 800.527.0218	 www.standard.com
Flexible Spending Accounts			
American Fidelity Company • Home Office • Fresno Office • Insurance Claims Fax • FSA Claims Fax	 501, 502, 503, 504, 506, 507	 800.662.1113 866.504.0010 800.818.3453 844.319.3668	 www.americanfidelity.com
Employee Assistance Plan			
Claremont EAP		800.834.3773	www.claremonteap.com

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